

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155153		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 04/02/2012	
NAME OF PROVIDER OR SUPPLIER HEALTHWIN				STREET ADDRESS, CITY, STATE, ZIP CODE 20531 DARDEN RD SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/20/12 and a Preoccupancy Survey for rooms 281 through 289 with one bed in each room except for room 285 which has two beds was conducted by the Indiana State Board of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/02/12</p> <p>Facility Number: 000073 Provider Number: 155153 AIM Number: 100288820</p> <p>Surveyor: Robert Booher, Life Safety Code Specialist</p> <p>At this PSR and Preoccupancy survey, Healthwin was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2-2.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities</p> <p>This two story facility with a basement was determined to be of Type II (222) construction and was partially sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident sleeping rooms. The facility has a capacity of 143 and had a census of 122 at the time of this survey.</p>			{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 000}	Continued From page 1 Quality Review by Dennis Austill, Life Safety Code Supervisor on 04/03/12.			{K 000}			